STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005044	A. BUILDING: _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REID HEALTH	1100 REID PKWY RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State complaint. Complaint Number: IN00174876 Unsubstantiated: Lack of sufficient evidence. Date: 11-05-15 Reid Health is in compliance with 410 IAC 15-1.5-5, Medical Staff, Indiana Hospital Licensure Rules. QA: cjl 12/31/15	S 000		